in the

Supreme Court

of the

United States

OCTOBER TERM, 1975

NO. 75-8861

KENNETH B. FORMAN,

Petitioner,

vs.

MASSACHUSETTS CASUALTY INSURANCE COMPANY,
a Massachusetts Corporation,

Respondent.

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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MIAMI REVIEW — 371-4853 — 377-3721

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KENNETH B. FORMAN, as Petitioner, seeks a writ of certiorari to review the decision and judgment

[SA: 1-14] of the United States Court of Appeals for the Fifth Circuit in an cause entitled **MASSACHUSETTS CASUALTY INSURANCE COMPANY, Appellant vs. KENNETH B. FORMAN, Appellee, reported in 516 F2d** 425, and the subsequent decision and judgment [A: 25-26] **denying Appellee's Petition for Rehearing, wherein the judgment [R: 582-585] and Amendment to Final Judgment [R: 600-601] of the United States District Court for the Southern District of Florida was reversed in part; affirmed as modified, in part and remanded. We shall refer in this brief to matters included in Petitioner's Appendix** thus [A:] and to matters included in the Respondent's Supplemental Appendix submitted with this brief thus [SA:]; all record references indicated thus [R:] are to the record on appeal below. All italics are in original text; text of opinions in bold-face are ours for emphasis unless otherwise stated.

STATEMENT OF THE CASE

On October 13, 1969, KENNETH B. FORMAN, hereinafter referred to as "FORMAN", made an application [R: 9, R: 20, R: 182-184] to MASSACHUSETTS CASUALTY INSURANCE COMPANY, hereinafter referred to as the "COMPANY", for issuance to him of an accident and health insurance policy which included [R: 20, R: 183] certain Declarations to Medical Examiner, both parts of which were signed by FORMAN in which he denied any prior history of diabetes. Relying upon said application [R: 182-184] the COMPANY issued to FORMAN the accident and health insurance policy [R: 7-20] for which he had applied, the effective date of the term of

which was November 20, 1969 [R: 7] which insured FORMAN "against loss resulting from —

> (1) Accidental bodily injury **occurring during the term of the policy** (hereinafter referred to as "such accidental bodily injury") or,
>
> (2) Sickness which **first manifests itself during the term of this policy** (hereinafter referred to as "such sickness"), to the extent hereinafter provided.

Said insurance policy contained a two-year incontestable clause in the form prescribed by Section 627.607 Florida Statutes. [R. 9]

On June 24, 1971, FORMAN executed a proof of loss and filed a claim [R: 29, Pl. Ex. 12] that he was totally disabled as result of diabetes, and that said sickness had commenced on February 19, 1970, and upon that claim, the COMPANY began making disability payments of $1,100.00 per month. On May 18, 1972, the COMPANY discovered for the first time [R: 181] that FORMAN had been confined as a patient of Dr. Maurice Dunst in a hospital in New York State, the first confinement commencing on September 7, 1968, and extending through September 20, 1968, and the second confinement commencing on November 14, 1968, extending through December 2, 1968 [R; 186-189,] during which FORMAN'S sickness had been diagnosed as diabetes mellitus. Dr. Maurice Dunst, FORMAN'S attending physician, testified [R: 437-465] that FORMAN was confined in Brookdale Hospital Medical Center in Brooklyn, New York, as his patient during the two periods mentioned above, during which his sickness was diagnosed as diabetes mellitus.

Later, during a deposition taken on January 19, 1973, [R: 211-229] FORMAN testified fully concerning his admission and confinement as a patient in Brookdale Hospital Medical Center for a period of approximately two weeks following each admission, making a total of approximately four weeks [R: 228-229] during which he was confined as a patient during which his sickness was diagnosed as diabetes mellitus.

On November 16, 1971, the COMPANY as Plaintiff, filed a Complaint against FORMAN, as Defendant, in the United States District Court for the Southern District of Florida, invoking jurisdiction upon the ground of diversity of citizenship [R: 1-20] to rescind and cancel said accident and health insurance policy upon the ground that in his application for said policy FORMAN had misrepresented the amount of his "monthly earned income", the only ground then known to the COMPANY, since at that time the COMPANY had not discovered FORMAN'S false representations in his application [R: 9, R: 20 and R: 182-184] that he had no prior history of diabetes. As soon as the COMPANY discovered said misrepresentations, it filed an application for leave to file an amendment [R: 189-191] asserting those misrepresentations as additional ground for rescission and cancellation, and on April 10, 1973 [R: 451] that application was granted, and on September 18, 1973, the Court entered an order [R: 558] that said amendment [R: 189-191] should **"relate back to the filing of the original complaint pursuant to Rule 15(c) Federal Procedure"**, and set the cause for trial, which resulted in a final judgment [R: 582-586; A: 1-6] and an amendment to said final judgment [R: 600-601; A: 7-8] from which the COMPANY appealed [R: 606] to the

United States Court of Appeals for the Fifth Circuit, which rendered the judgment [A: 27-28] which FORMAN, as Petitioner, seeks to review by writ of certiorari.

Petitioner's Statement of the Case

Petitioner's "Statement of the Case", includes the following:

> "The policy in issue resulted from defendant FORMAN'S action in the latter part of 1969, seeking health and accident disability insurance from one Allen Davis, an insurance agent in New York * * * **Davis mailed FORMAN a blank Massachusetts Casualty application form** (R. 19) **with instructions to sign where he, Davis, indicated and return it to him** in New York. (Trial Record References) **Thereafter Davis himself, without Forman supplying answers, completed the application** (Trial Record References) **dated October 13, 1969, and filed it with** the insurance company." (See: Petition, p. 5) * * * Nevertheless, **Forman asserted** at the same time that he had not supplied answers to the question on the insurance application." (See: Petition, p. 8)

The Court of Appeals for the Fifth Circuit, in its opinion, and judgment here sought to be reviewed, rejected [Footnote 5, p. 6738, SA: 13] this contention:

> "5. The District Court found that Forman signed the application in blank and sent it to the agent, who filled in the answers called for. Despite re-

peated assertion to the contrary in Forman's brief, the District Court made no finding of fact as to who furnished to the agent the information embraced in the false answers. (Also, the court did not address itself at all to the several false statements in the representations to the medical examiner, which were a second part of the application and were signed by Forman and attested by him to be true and correct.)

The trial court conducted a hearing on attorney fees several months after the decision on the merits. Forman elevates to the dignity of "findings" one or more informal statements made by the court at this hearing and arguably indicating that Forman did not supply the agent with the subject matter of the answers. The judge made the statements in colloquy with counsel during the process of recalling to his mind the details of the case and of the merits decision. These were not findings. If they had been we would hold them plainly erroneous. The evidence is overwhelming that the information contained in the misrepresentations originated with Forman."

We suggest that **the facts** as found and stated by the Court in the decision here sought to be reviewed **are the facts** proper for consideration here.

QUESTION PRESENTED

We shall re-state the question presented in the form stated by Petitioner's Counsel:

> "WHETHER THE FIFTH CIRCUIT HAS CONSTRUED FLORIDA STATUTE §627.607 SO AS TO REACH A RESULT DIRECTLY OPPOSITE TO AND CONFLICTING WITH CLEAR AND CONTROLLING RULINGS BY THE SUPREME COURT OF FLORIDA ON AN ASPECT OF STATE INSURANCE LAW HAVING MAJOR IMPORTANCE."

Said **question** arose out of the lower court's resolution of these two points:

First: The insuring agreements of the accident and health insurance policy [R: 7] read as follows:

> "* * * the COMPANY does hereby insure the above-named policy holder * * * against loss resulting from
>
> (1) Accidental bodily injury **occurring during the term of the policy** (hereinafter referred to as "such bodily injury") or,
>
> (2) Sickness which **first manifests itself during the term of this policy** (hereinafter referred to as "such sickness"), to the extent hereinafter provided."
>
> * * *

"This policy is effective from 12 o'clock noon standard time on the policy date * * * the term specified in the policy schedule * * * Policy date: November 20, 1969."

The Court determined [Text 1, 2, p. 6734-6735] that FORMAN'S diabetes **"had first manifested itself** before the policy became effective", and therefore his claim for disability by reason of "such sickness" was not within the coverage of the policy.

Second: Said policy contained a provision, required by Section 627.607 Florida Statutes, quoted by the Court of appeals as follows:

"B. No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

Did said provision, required by Section 627.607 Florida Statutes, bar the COMPANY from contesting FORMAN'S claim upon the ground that said claim was not covered by the policy? The Fifth Circuit answered "No" and held that the COMPANY was not barred from contesting FORMAN'S claim upon the ground that said claim was not covered by said policy.

We respectfully submit that the **QUESTION PRESENTED** and the points out of which it arose were answered correctly in accordance with Florida law, controlling decisions of the Florida courts, which we shall review hereinafter.

First Point — "First Manifest" Rule

In the case at bar, it was conclusively established by FORMAN's belated admissions [R: 295-298] that he had been confined as a patient of Dr. Maurice Dunst in Brookdale Hospital Medical Center in Brooklyn, New York, for a period of two weeks, from September 7, 1968, to September 20, 1968, and for a second period between November 14, 1968 and December 2, 1968, and during those two periods while he was confined as a patient in that hospital his sickness or physical condition was diagnosed by his attending physician as diabetes mellitus and at all times after December 2, 1968, FORMAN "knew and was aware of the fact that he was a diabetic, and that his condition had been diagnosed to be diabetes mellitus." [R: 296-297] It is equally certain that the policy term began on November 20, 1969.

The rule established in Florida and the Fifth Circuit followed in 22 other jurisdictions.

In a Note in **53 ALR 2d. 686, 689,** and its continuation in the pocket-part, the rule established in Florida and the Fifth Circuit is stated, supported by decisions in 19 other jurisdictions as follows:

"It is generally recognized that provisions in a health or hospital insurance policy requiring that

the illness or disease from which the assured suffers originate a specified time after the date of the policy to be within the policy coverage are strictly construed against the insurer, **and the illness, disease, or disability will ordinarily be deemed to have its inception when it first becomes manifest or active or when there is a distinct symptom or condition from which one learned in medicine can with reasonable accuracy diagnose the disease."**

Note: 53 ALR 2d 686, 689

To the 19 jurisdictions listed in support of that rule, must be added the following:

(1) **Continental Casualty Company vs. Robertson** (CA-5-GA.) **245 F.2d. 604**

(2) **Continental Casualty Company v. Foolen** (Fla. App. 3- 1974) **293 So.2d. 758**, citing note **53 So.2d 686, 689;**

(3) **Boyle v. Springfield Life Insurance Co. 38 Fla. Supplement 84,** citing note **53 ALR 2d. 689,** affirmed in **Springfield Life Insurance** Company v. Boyle (Fla.App.4-1973) 272 **So.2d. 826**

(4) **Jack L. Turner v. Union Fidelity Life Insurance Co.** (Fla. App. 2 - Sept. 12, 1975) **319 So.2d. 588,** citing note **53 ALR 2d 686**

(5) **Time Insurance Company v. Arnold** (Fla. App. 1 - October 10, 1975) **319 So.2d. 638,** recognizing the rule stated in 53 ALR 2d 686.

(6) **Mutual Hospital Insurance Inc. v. Klapper** (Ind. 1972) **288 NE 2d 279**

(7) **Southards v. Central Plains Insurance Co.** (Kansas 1968) **201 Kan. 499, 441 P2d 808**

(8) **Ray v. Hospital Care Ass'n.** (1952) **236 NC** 562, 73 SE 2d 475

(9) **Randa v. Bear** (1957) **50 Wash. 2d 415, 312 P.2d 640**

Thus, in addition to the Florida and Fifth Circuit decisions, following the rule stated in **53 ALR 2d. 686, 689,** we have added five (5) other jurisdictions, making a total of **24 jurisdictions throughout the United States which follow the rule.**

Counsel have cited on pages 11 and 12 of the Petition for certiorari statutes of twenty-eight (28) states and the District of Columbia, which Counsel say (p. 11) are at least in substance the same as Section 627.607 Florida Statutes, to indicate the importance of the question they seek to review. We have not read the statutes cited, but accepting Counsel's statement as correct, we call attention to the fact that the note in **53 ALR 2d. 686, 689** with the additional cases we have cited above, fourteen (14) of those twenty-eight (28) states follow the rule stated in 53 ALR 2d. 686, 689 which is also the rule established in Florida and the Fifth Circuit.

The Rule in the Fifth Circuit

In **Continental Casualty Company v. Robertson** (CA-5-Ga.) **245 F.2d 604,** (See — SA: 1-14) a polio policy **applied for on July 7, 1954,** and **effective on July 22, 1954,** contained this provision:

> "When any member of the family shall, by reason of poliomyelitis **which first manifests itself after the effective date of this policy,** require treatment commencing while this policy is in force . . . the Company will pay for the following items of expense . . ."

Robertson's infant daughter **became ill on July 18, 1954,** but her illness was not diagnosed by doctors as polio until **July 26, 1954,** which was **after the effective date of the** policy. The insurance company contended that the claim was not covered because the child became ill on July 18, 1954. The Fifth Circuit held that the disease **"first manifested itself"** when the doctors first diagnosed the illness as poliomyelitis, and therefore it was covered.

Judge CAMERON, speaking for the Court said:

> "* * * The crucial question is **when, during the days intervening between July 18th and July 26th, the illness 'manifested itself' to be polio.** * * *
>
> "The infant became ill July 18th, and a general practitioner was called in, who found a sore throat and fever and administered penicillin. The family doctor returned to town on the 19th

> and relieved the physician first called, and the infant was brought to his office. He found the same symptoms present and gave a second injection of penicillin. She was brought back to his office on the 20th and, chiefly because she had not responded to the penicillin, she was taken to a hospital where other doctors were called into consultation. At that time she experienced difficulty in walking and the congestion in nose and throat persisted. All of the doctors, proceeding with the caution which ordinarily leads them to view all afflictions at that time of year as such, suspected that the illness might be polio; **but they were unable to diagnose it as polio because all of the symptoms then existing were commonly found in a number of other diseases.** But, although he had asked them 'many many times', **they did not advise Appellee that they diagnosed the child's illness as polio until July 26th. which was the first time the symptoms had become sufficiently pronounced to permit them to classify it with any degree of assurance.**
>
> "The tendency of the Georgia law to emphasize the 'usual and common signification' of word meanings make dictionary definitions important in determining whether, as contended by appellant, the evidence required the court to hold, as a matter of law, that polio had manifested itself on or before July 22nd. The transitive verb 'manifest' is thus defined: 'To show plainly; to make to appear distinctly; to put beyond question or doubt; to display; exhibit; reveal; prove; evince, evidence.' The essential import of this

definition is to recognize the verb 'manifest' as embracing the concept of demonstrating plainly, distinctly, or beyond question.

"Appellant's argument is bottomed upon the contention that the policy before us would not impose liability upon the company if polio had its origin or inception on or prior to July 22nd. **The Company could have chosen language of such meaning, but it did not do so. It inserted a word possessing a more exacting connotation, one contemplating the advancement of the disease beyond the point of origin and to the state where its presence was plain, distinct or beyond question or doubt."**

The Florida Cases Follow the Fifth Circuit

Boyle v. Springfield Life Insurance Co., 38 Florida Supplement 84, affirmed in **Springfield Life Insurance Co.** vs Boyle (Fla. App. 4-1973) **272 So.2d** 826, (See — **SA: 29-39**) involved a hospitalization policy:

> "• • • insuring against loss resulting from 'sickness' of any covered dependent contracted and commencing while the policy was in force, the term 'dependent' including any unmarried child between the ages of 14 days and 23 years inclusive and dependent upon the insured." [Text 84, 85]

The policy was issued **June 2, 1965,** and the application showed that the insured's wife was at that time ap-

proximately six months pregnant, and on July 5, 1965, a boy was born. The facts, and the applicable rule were stated by Judge **WARREN** as follows:

> "From the briefs of the parties it appears that from the plaintiff's point of view the question is whether the policy involved covers a child who was diagnosed and treated after reaching the age of 14 days, as having a congenital condition; or, as the defendant states it, whether or not the infant had a "sickness" which was "contracted and commenced" during the time the policy was in force as to him.
>
> It will be recalled that the policy insured against loss resulting from "sickness" of a covered dependent, such a dependent including an unmarried child between the ages of 14 days and 23 years inclusive.

The principle applicable to this case is found in **53 ALR2d, Insurance — Inception of Sickness §3, p. 689,** as follows — "It is generally recognized that the provisions in a health or hospital insurance policy requiring that the illness or disease from which the assured suffers originate a specified time after the date of the policy to be within the policy coverage are strictly construed against the insurer, and **the illness, disease, or disability will ordinarily be deemed to have its inception when it first becomes manifest or active or when there is a distinct symptom or condition from which one learned in medicine can with reason-**

able accuracy diagnose the disease." See also Couch on Insurance 2d, §41:814, and Appleman 1A, Insurance Law and Practice §406.

In Couch it is said, "In consequence of the distinction between 'sickness' and 'disease,' there is coverage under a 'sickness' policy of a 'sickness' which first manifests itself during the period of the policy even though it is traceable to a diseased condition which antedated the policy, absent any element of fraud or breach of warranty or condition, etc., which would make the policy void or voidable. That is, it is generally recognized that provisions in a health or hospital insurance policy requiring that the illness or disease from which the insured suffers originate a specified time after the date of the policy to be within the policy coverage are strictly construed against the insurer, and the illness, disease, or disability will ordinarily be deemed to have its inception when it first becomes manifest or active, or when there is a distinct symptom or condition from which one learned in medicine can with reasonable accuracy diagnose the disease."

In Continental Casualty Company v. Gold, Fla., 194 So.2d 272, upon which both parties rely, the jury, which had been presented with conflicting evidence as to when the condition causing hospitalization first became manifest, found in favor of the claimant. The Supreme Court in affirming was inclined to believe that the weight of authority supported the trial court's instruc-

tion to the jury, which was to the effect that one is regarded as sick only when his diseased condition has advanced far enough to incapacitate him. In that case the court stated at page 275 — In 29 Am. Jur., Insurance, §1154, 301, the text reads:

> "The words 'sickness' and disease' are technically synonymous, but when given the popular meaning as required in construing a contract of insurance, 'sickness' is a condition interfering with one's usual activities, whereas disease may exist without such result; in other words, one is not ordinarily considered sick who performs his usual occupation, though some organ of the body may be affected, but is regarded as sick when such diseased condition has advanced far enough to incapacitate him." We believe this is the general rule that governs this case; it supports the trial judge's ruling. The insurer could have protected itself in the terms of the policy in this particular had it deemed it advisable, by limiting its liability solely to a "disease" originating after a certain time stated in the policy or by stipulating that it did not cover "sickness" whose symptoms appeared prior to the effective date of the policy. This it did not do. It used the term "sickness" interchangeably with "disease" in respect to the time of its liability and, as we have seen, this word connotes incapacitation to perform one's usual occupation. See again 29 Am.Jur., Insurance, §1154, page 301, to the effect that in a situa-

tion of this kind the construction of the policy should favor the insured. The text there reads in part:

> "In determining what losses are covered by policies insuring against losses on account of disease or sickness, the general rule that ambiguous or uncertain provisions will be construed most favorably to the insured is applied. * * *"

The court believes that the facts herein come within the **Gold** case above.

While Dr. Gluck on July 8, 1965, found a congenital cardiac defect, it was satisfactory, and the child was discharged to its home two days later, he having mild cyanosis at the time. On July 15th, when the examining physician next saw the child after its discharge, which was within a few days of the 14 days inclusive period under the policy, there was noted cyanosis on crying, but the rest of the examination was negative.

According to the mother, during his first month the child ate and slept well, reacted normally, was not on medication or restricted, and had no problems, other than turning a little blue when he cried.

It was well after 14 days from the child's birth that Dr. Gluck found the change in the child of considerably increased blueness on August 2nd,

which led her to change her diagnosis from truncus arteriosos to transposition, to find that prognosis was poor and that it was likely that the infant would develop cardiac failure, and to suggest cardiac studies which, when she originally saw the baby, she did not think worth doing because she was not concerned about the baby. And it was the result of the cardiac studies on August 18th, confirming transposition, which induced the reference by her to the specialist in Texas. These facts brought the matter within the **Gold** case and the general statements of the law as found in ALR2d and Couch above. The sickness under the policy became active and a distinct changed condition appeared from which the heart specialist could diagnose the disease; the condition had commenced and had advanced far enough to incapacitate the child.

The BOYLE case was decided squarely upon the principle announced and applied in **Continental Casualty Company v. Robertson,** supra, that a "sickness" has its inception **not at the date of its medical origin in the body, but when it has advanced beyond the point of origin to such a point that one learned in medicine can with reasonable accuracy diagnose the disease.**

Continental Casualty Company v. Fooden, (Fla. App. 3-1974) **293 So.2d 759** (See: SA: 23-28) was a case in which the insured sought to recover benefits under a policy for disability which he alleged resulted from a paralysis of Fooden's left arm which first appeared following surgery to that arm on March 15, 1971, which had been performed to correct an insufficiency of the right carotid artery.

The Court **held** that although the insured had suffered from arteriosclerotic cardiovascular disease since approximately 1965, his disability resulting from the paralysis of his left arm was first diagnosed following that surgery and was covered by the policy. The Court said:

> **"According to the appellant, since plaintiff undeniably had heart disease some five years prior to the effective date of the insurance policy and in fact consulted a doctor within twelve months prior to the issuance of the policy, he does not fall within the definition of 'sickness' in the policy.**
>
> "However, this argument ignores language in the policy in the immediately preceding sentence: '"Sickness" wherever used in the policy means sickness or disease which causes disability covered by the policy commencing while the policy is in force as to the insured.'
>
> "In our view this case falls within the rule enunciated in Continental Casualty Company v. Gold, Fla.1967, 194 So.2d 272 that in determining what losses are covered by an insurance policy insuring against loss due to sickness or disease, ambiguous or uncertain provisions will be construed in favor of the insured.
>
> "[1] Similarly, **provisions in such policies which require that a sickness or disease originate at some specified time after the policy takes effect in order to provide coverage are strictly construed against the insurer.** See, **Annot., 53**

> **ALR2d 686, 689; Boyle v. Springfield Life Ins. Co., Cir.Ct. 1972, 38 Fla.Supp. 84, aff'd Springfield Life Ins Co. v. Boyle, Fla.App.1973, 272 So.2d 826.**
>
> "In Continental Casualty Company v. Gold, supra, the Supreme Court stated that the word 'sickness' connotes a diseased condition which has advanced far enough to incapacitate an individual from performing his usual activities.
>
> "In this case, Dr. Spear testified that arteriosclerosis, which afflicted the plaintiff, is 'an inescapable part of aging' which everyone develops to some degree. Dr. Spear further described the disease as 'segmental' which at different times may affect certain vessels and involve only specific areas of the body.
>
> "[2] **We think the evidence in this case establishes that the 'sickness' which disabled the plaintiff became active and was diagnosed by Dr. Spear after the policy became effective. The incapacity to plaintiff's left arm was not manifested until after the March 15th operation."**

Jack L. Turner v. Union Fidelity Life Insurance Company, (Fla.App. 2-September 12, 1975) **319 So.2d 588,** which cites the note in **53 ALR2d 686,** upon its facts is on all fours with the case at bar as a comparison will show:

Facts in Forman Case

The effective date of FORMAN's policy was November 20, 1969, and insured against loss resulting from "sickness" which first manifested itself during the term of said policy which commenced on November 20, 1969. In 1968, commencing on September 7, 1968, FORMAN became sick, and was confined as a patient in a hospital on two occasions extending to December 2, 1968, during which confinement, his attending physician diagnosed his "sickness" as diabetes mellitus. FORMAN made no claim that his "sickness" during 1968 was covered by the policy, but on February 19, 1970, which was "during the term" of said policy, FORMAN claimed to have become disabled as result of diabetes, the same physical condition or sickness from which he had suffered in 1968, and sought to recover benefits for the second "manifestation" of said sickness.

Facts in Turner Case

The effective dates of TURNER's two policies were May 11, 1971, and June 24, 1971, and excluded from coverage sickness from "heart trouble only if contracted more than six months after the effective dates of the policy." On November 9, 1971, Turner was hospitalized as result of a heart attack, and remained in the hospital until December 2, 1971, which was during and within the six months exclusionary period. Turner conceded there was no policy coverage for that heart attack, but on November 4, 1972, more than six months after the effective date of said policies, TURNER suffered a second heart attack caused by arteriosclerosis, the underlying cause of the first attack and sought to recover benefits for the second "manifestation" of said sickness.

The trial court entered judgment for the insurer, as did the Fifth Circuit in the case at bar. Judge SCHEB, speaking for the Court in the TURNER case said:

> "The trial court concluded that each of Turner's periods of disability was caused by 'heart trouble' contracted on November 9, 1971, within the six months exclusionary period. Judgment was entered in favor of the insuror, and Turner appeals.
>
> **"The undisputed medical evidence shows that Turner's second heart attack was a recurrent manifestation of an underlying coronary heart disease (arteriosclerosis) which manifested itself within six months of issuance of the policies. An illness, disease or disability ordinarily is deemed to have been 'contracted', i.e., to have its inception when it first becomes manifest or active. See 53 A.L.R.2d 686; 17 C.J.S. Contract p. 512 (1963).** The trial court, therefore, correctly determined **that the disability resulting from the second heart attack was a continuation of the 'heart trouble' which originally was contracted during the six months exclusionary period.**
>
> "Accordingly, the judgment of the trial court is affirmed."

Continental Casualty Company v. Gold (Sup.Ct.-1967) **194 So.2d 272** differs from the cases we have reviewed in several important respects: **First,** a study of that decision [SA: 15-22] does not show when, if ever, the insured's

physical condition, malady or disease was "diagnosed," nor is the nature or cause of her illness stated or shown. **Second,** the Supreme Court stated [SA: 20] that:

> "• • • the jury was presented with **conflicting evidence as to when the condition causing** [plaintiff's] **hospitalization first became manifest.**"

Third, the Court expressly recognized [SA: 21] that a provision limiting the insured's liability such as contained in the FORMAN policy in the case at bar would require a different result:

> "**The insurer could have protected itself** in the terms of the policy in this particular had it deemed advisable, **by limiting its liability solely to a 'disease' originating after a certain time stated in the policy or by stipulating that it did not cover 'sickness' whose symptoms appeared prior to the effective date of the policy. This it did not do.**"

In the case at bar, MASSACHUSETTS CASUALTY **did what the insurer did not do in the Gold case, it limited its liability to "sickness" which first manifests itself during the term of this policy;** and, we submit that having done so, the case at bar was not controlled by the **Gold** case.

Fourth, the Court held that the manner in which the case had been tried [SA: 21-22] precluded a reversal.

In the case at bar, the Respondent-insurer proved without controversy, the facts which the insurer had not proved in the **Gold** case: That is, that FORMAN was sick

and confined in a hospital as a patient for a period of approximately four weeks between September 3, 1968, and December 2, 1968, and that during that period his sickness was diagnosed by his physician as diabetes mellitus [R: 101; 228] from which **"a reasonable inference may be drawn,"** as the Court said in **Gold** [SA: 22], **"that these were the dates when** [FORMAN] **was incapacitated,"** that is in 1968 before FORMAN had even applied for the policy.

These authorities, we submit, supported the decision of the Fifth Circuit [A: 25-26] denying FORMAN's Petition for Rehearing:

"PER CURIAM:

> "Neither Continental Casualty Co. v. Gold, 194 So.2d 272 (Fla., 1967), nor Continental Casualty Co. v. Fooden, 293 So.2d 758 (Fla.App., 1974), requires that we affirm the trial court. In neither of those cases was there evidence, such as there is in the present case, that before the effective date of the policy the insured's condition, by reason of its disabling consequences, was a 'sickness' as opposed to a mere 'symptom' or a 'disease.'
>
> "The Petition for Rehearing is denied and no member of this panel nor Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35 Federal Rules of Appellate Procedure; Local Fifth Circuit Rule 12), the Petition for Rehearing En Banc is denied."

Concluding our discussion of the First Point, we submit that Petitioner's contention that a direct conflict exists between the decision of the Fifth Circuit in the FORMAN case [SA: 1-14] and the decisions of the Courts of Florida in Continental Casualty Company v. Gold [SA: 15-22] and Continental Casualty Company v. Fooden [SA: 23-28] is without merit, and that the Fifth Circuit did not fail or refuse to comply with the Mandate of ERIE RY. CO. v. TOMPKINS, relied upon to invoke this Court's jurisdiction on certiorari.

Second Point — Incontestable Clause Does Not Bar Contest Upon Ground of No Coverage

The statutory incontestable provision of the FORMAN policy, required by Section 627.607 Fla. Statutes, as quoted by the Court of Appeals, reads as follows:

> "**INCONTESTABLE: A.** After this Policy has been in force for a period of two years during the lifetime of the Insured, it shall become incontestable as to the statements contained in the copy of the application. **B. No claim for loss incurred or disability (as defined in the Policy) commencing after two years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.**"

Having decided upon the authorities which we have discussed, that FORMAN's claim for disability benefits

by reason of diabetes was not covered by the policy, the Fifth Circuit decided and held that said incontestable provision did not bar the insurer from contesting FORMAN's claim under said policy upon the ground that said claim was not within the coverage of said policy:

> "In this case the condition for which Forman claimed benefits had 'first manifested' itself almost a year before the policy became effective. **Thus disability resulting from diabetes was never within the scope of policy coverage, and Forman cannot now claim diabetes-related disability benefits unless the incontestability provisions of the policy caused this prior-existing illness to become covered. We conclude that they did not have that effect.**"

Petitioner argues (Petition for Cert., pp. 15-16) to the contrary, contending that any contest of FORMAN's claim, **even upon the ground that said claim was never within the policy's coverage,** was excluded by said statutory incontestable provision. That contention has been resolved against Petitioner by the recent decision in **HOME LIFE INSURANCE COMPANY v. REGUEIRA** (Fla.App. 2-May 28, 1975) **313 So.2d** 438 [SA: 44-52] in which the Court held that an incontestable policy provision required by **Section 627.560 Fla. Statutes,** did not bar the insurer's defense upon the ground that the policy holder's claim was not within the coverage of the policy:

> "We consider this day the question of whether an incontestability clause contained in a group life insurance policy bars the insurer from defending against a claim on the ground that the

insured was not an employee eligible for insurance under the terms of the policy. **It appears to be a case of first impression in Florida.**

* * *

The policy also contained the following incontestability clause as required by § 627.0409, F.S. 1965 (now § 627.560, F.S. 1973):

> " **'This policy shall be incontestable after two years from the date of issue, except for the non-payment of premiums.'**

"Appellant sought to defend the action on the grounds that the decedent was not indeed a full-time employee within the afore-quoted eligibility provisions. The trial judge, however, held that the defense was barred under the aforesaid incontestability clause, disallowed the defense and entered a final summary judgment in favor of plaintiff-appellee for the full benefits under the policy together with attorney's fees, interest and costs. We reverse.

"[1, 2] **At the outset we agree with the trial judge that appellant did not properly 'contest' the policy within the two-year limitation period of the incontestability clause.** Plaintiff-appellee did file the claim herein within that period, and appellant had indeed rejected it within that period. But the law is clear on the point that an insurer must 'contest' a policy by the invocation of judicial action, either by way of claim or de-

fense, within the limits prescribed in an incontestability clause or be forever barred thereby. Couch puts it this way:[1]

> " 'As a general rule, a clause in an insurance policy making it incontestable after a certain period imports the invoking of judicial action to cancel the policy, or to prevent its enforcement, either by a suit to that end, or by a defense to an action on the policy; in fact, such a clause can be taken advantage of in no other method than by a judicial contest to which the insurer and the insured, or their representatives or beneficiaries, are parties.'
>
> * * *
>
> " 'An incontestable clause included in a life policy as required by statute contemplates and intends to require the institution within the specified period of a proceeding in court to cancel the policy on account of original invalidity, or the filing within that period, in a suit brought on the policy, of an answer setting up a ground of original invalidity to defeat recovery.'

So if the defense sought to be interposed herein is one which must be raised within the two-year contestability period, such defense is barred. **We are of the view, however, that it is not such a defense; and it is here that we respectfully depart from the conclusion of the trial judge.**

"[3] **The threshold question in these cases involving applicability of an incontestability**

[1] 18 G. Couch, Insurance § 72.98 (2d ed. 1968).

clause is whether the claim of the insurer relates to the validity of the policy or whether it relates to limitations of coverage. If it relates to the former it is barred; if to the latter it is not."

This Florida decision is squarely in accord with the Fifth Circuit's decisions in **Sanders v. Jefferson Standard Life Ins. Co.** (CA-5-Miss.) **10 F.2d 143; Washington National Life Ins Co. v. Burch, 270 F.2d 300,** and other authorities cited in the **FORMAN** decision.

CONCLUSION ON QUESTION PRESENTED

The basis for the Petition for Certiorari in this case is the Petitioner's contention that **Massachusetts Casualty Insurance Company v. Kenneth B. Forman** (CA-5-Fla.) 516 F.2d 425, conflicts with **Section 627.607 Fla. Statutes** and also conflicts with the decisions of the Florida courts in **Continental Casualty Co. v. Gold** (Sup.Ct. Fla.) **194 So.2d 272,** and **Continental Casualty Co. v. Fooden,** (Fla.App. 3-1974) **293 So.2d 758,** which, it is argued, is a departure from the principle established in **Erie R. Co. v. Tomkins, 304 U.S. 64** sufficient to invoke this Court's jurisdiction upon certiorari. We respectfully suggest that Petitioner's contention is without merit in view of the controlling Florida decisions upon each of the two points out of which said QUESTION PRESENTED arises, none of which are cited nor discussed in said Petition for Certiorari. It is not contended that the decision of the Fifth Circuit sought to be reviewed is in conflict with **(1)** the Constitution of the United States; **(2)** any federal statute; **(3)** any decision of this Court or decision of another Federal Court of Appeal, and we submit that there is no basis for review by certiorari, and said Petition for Certiorari should therefore be denied.

REASONS FOR GRANTING THE WRIT

We have shown that **Massachusetts Casualty Insurance Company v. Forman** (CA-5-Fla. 1975) **516 F.2d 425,** is not in conflict with **Section 627.607, Fla. Statutes,** as exemplified by **Home Life Insurance Company v. Reguiera** (Fla.App. 2-May 28, 1975) **313 So.2d 438,** nor with the decisions in **Continental Casualty Co. v. Gold,** supra, and **Continental Casualty Co. v. Fooden, supra,** but on the contrary, the decision in the **FORMAN** case, and decisions of the Appellate Courts of Florida follow the rule adopted in 22 other State jurisdictions collected in 53 ALR2d 686, 689, particularly as exemplified by **Turner v. Union Fidelity Life Insurance Company** (Fla.App. 2-September 12, 1975) **319 So.2d 588; Time Insurance Company v. Arnold,** (Fla.App. 1-October 10, 1975) **319 So.2d 638; Continental Casualty Insurance Co. v. Fooden,** supra; and **Boyle v. Springfield Life Insurance Co.,** supra. These decisions demolish any contention that in the **FORMAN** case, the Court departed from the mandate of **ERIE RY. CO. v. TOMPKINS, 304 U.S. 64,** the only basis for the Petition for Certiorari.

We respectfully suggest that if, as we have shown, the decision in the FORMAN case does not conflict with Section 627.607 Fla. Statutes, nor with decisions of the

Florida Courts, there is no reason for granting the Writ, and respectfully submit that said Petition for Certiorari should be denied.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that three (3) copies of the foregoing Brief in Opposition to Petition for Certiorari were served upon Burton Young and William L. Rogers of SNYDER, YOUNG, STERN, BARRETT & TANNENBAUM, P. A., 17071 West Dixie Highway, North Miami Beach, Florida 33160, Attorneys for Petitioner, Kenneth B. Forman, by mailing three (3) copies thereof to them by United States Mail, First Class Postage prepaid, pursuant to Rule 33 of this Court, this 9th day of January, 1976.

L. J. CUSHMAN
Of Counsel